Instruction Manual for the Client Data Project

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Health Resources and Services Administration
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CDP PROVIDER- AND CLIENT-LEVEL FORMS

A data file consisting of all the information contained in the Client Data Project (CDP) forms shall be submitted by all grantees and contractors/sub-contractors who are recipients of Title III and/or Title IV funding. There are two separate forms, a Provider-Level form and a Client-Level form. Likewise, two data files shall be submitted to the HIV/AIDS Bureau (HAB), one consisting of all provider-level data elements and a client-level file consisting of all unduplicated client records.

Grantees are required to submit the Provider-Level data quarterly, along with the Client-Level data. Much of the information is static, needing only to be filled out once a year. Some of the information should only be filled out at the end of the year, including HIV Counseling Information and Title III Funding Information.

Each data submission is cumulative: in April, only one quarter of data is submitted. In July, an updated file is sent that includes information and updates from January-June. The submission process continues so in October, the file includes information from January - September, and at the end of January, the file containing all information for the entire previous year is submitted. Many items need to be updated only once a year (e.g. Pap smears) ; others may need to be updated only once in the client's life (e.g. that the client was vaccinated, or treated for TB). Other fields are updated regularly, such as service visits, referrals, CD4 counts and viral loads. Data are reported to HAB on a quarterly basis so that data quality problems can be quickly identified and corrected before the end of the year. More importantly, it is expected that the CDP grantees will use their data in regular clinic management and quality improvement activities.

REPORTING PERIODS

The reporting periods for the Client-Level data include the following:

- Quarter 1 January 1 through March 31;
- Quarter 2 April 1 through June 30;
- Quarter 3 July 1 through September 30; and
- Quarter 4 October 1 through December 31.

Grantees are required to submit their data to HAB/HRSA one month after the end of the quarter, for the preceding quarter.

Data submission are expected to arrive at HRSA by the following dates:

- Quarter 1 – April 30th
- Quarter 2 – July 30th
- Quarter 3 – October 30th
- Quarter 4 – January 30th

GENERAL INSTRUCTIONS

While completing the CDP forms, keep in mind the following:

- For closed-ended questions (i.e. where check-boxes are provided for your response), provide only ***one*** response, unless instructed otherwise.
- All closed-ended questions require a response, unless a skip is invoked during a series of questions.
- Leave open-ended questions (e.g. dates, counts etc.) blank if the information is not available, unless instructed to fill in a "zero."
- Before submitting data to HRSA, remember to update all questions, as necessary, and to answer all quarterly variables.

PROVIDER-LEVEL FORM

1. Provider name

Give the name of the agency/service provider for whom this data report is being completed.

Provider agency/service provider is the agency that provides direct services to clients (and their families) that are funded by the Ryan White CARE Act. Services may be funded through one or more Federal Ryan White CARE Act grants or through subcontract(s) with official Ryan White CARE Act grantees. A provider may also be a grantee, such as in Titles III and IV.

Questions 2 through 3e refer to the provider agency listed in Question 1.

2. Provider address

a. Street

Enter the street address of the provider listed in Question 1 (where service is provided).

b. City

Enter the city of the provider listed in Question 1.

c. State

Enter the state of the provider listed in Question 1.

d. ZIP code

Enter the five-digit ZIP code of the provider listed in Question 1.

e. Provider ID

Report the unique 4-digit provider ID number.

f. Taxpayer ID

Give the unique 9-digit taxpayer ID number of the provider agency. This number has been given to the agency by the Internal Revenue Service and is a taxpayer identifying number issued to an organization or agency, upon application, for use in connection with filing requirements.

3. Contact information

a. Name

Enter the name of the contact person at the provider agency listed in Question 1 who is responsible for completing the data in this report.

b. Title

Enter the title of the person listed in Question 3a.

c. Phone number

Enter the telephone number, including the area code, of the person listed in Question 3a.

d. Fax number

Enter the fax number, including the area code, of the person listed in Question 3a.

e. Email address

Enter the email address of the person listed in Question 3a.

4. Person completing this form

a. Name

Enter the name of the person at the agency (as defined in Question 1) who is completing this form.

b. Phone number

Enter the telephone number, including the area code, of the person listed in Question 4a.

c. Email address

Enter the email address of the person listed in Question 4a.

5. Calendar Year for Reporting

Enter the start and end dates of the reporting period for the provider agency. The dates should be be January 1-December 31st of the current year, unless the agency began receiving CARE Act funding after January 1.

6. Reporting scope

Indicate the reporting scope for the collection of the data in this report using the predetermined response codes listed below. Select only one response code.

Reporting Scope 1: ALL clients receiving a service ELIGIBLE for Title I, II, III, or IV funding.

Explanation: Reporting scope for providers reporting ELIGIBLE services. Data are based on all services that are eligible for funding from Ryan White Title I, II, III, or IV.

Under the ELIGIBLE reporting scope, clients receiving any service eligible for Ryan White Title I, II, III, or IV funding are included in the report even if the service was not paid for with Ryan White Title I, II, III, or IV funds. <u>This reporting scope is preferred by HRSA.</u>

Reporting Scope 2: ONLY clients receiving a Title I, II, III, or IV FUNDED service.

Explanation: Reporting scope for providers reporting FUNDED clients. Data are based on clients for whom services are paid for by Ryan White Title I, II, III, or IV funding.

Under the FUNDED scope, only clients receiving services paid for exclusively with Ryan White Title I, II, III, or IV funds are included in the report. Typically, this is a subset of the eligible reporting scope. Providers using the funded-only reporting scope must:

- Have an adequate mechanism for tracking clients and services by funding stream;
- Have secured prior approval from their grantee in consultation with HRSA; and
- Report actual numbers of clients and services.

7.□ a. Provider type

Using the provider types listed below, select the type of provider that best describes the agency completing this data report. ***Select only one choice.***

Provider types:

Hospital or university-based clinic includes ambulatory/outpatient care departments or clinics, emergency rooms, rehabilitation facilities (physical, occupational, speech), hospice programs, substance abuse treatment programs, STD clinics, AIDS clinics, and inpatient case management service programs.

Publicly funded community health center includes community health centers, migrant health centers, rural health centers, and homeless health centers.

Publicly funded community mental health center is self-explanatory.

Other community-based service organization (CBO) includes non-hospital-based organizations, AIDS service and volunteer organizations, private nonprofit social service and mental health organizations, hospice programs (home and residential), home health care agencies, rehabilitation programs, substance abuse treatment programs, case management agencies, and mental health care providers.

Health department includes State or local health departments.

Substance abuse treatment center is an agency that focuses on the delivery of substance abuse treatment services.

Solo/group private medical practice includes all health and health-related private practitioners and practice groups.

Agency reporting for multiple fee-for-service providers is an agency that reports data for more than one fee-for-service provider (e.g., State operating a reimbursement pool).

PLWHA coalition includes organizations of People Living with HIV/AIDS that provide support services to individuals and families affected by HIV and AIDS.

VA facility is a facility funded through the Veterans Administration.

Other facility includes facilities other than those listed above.

7. b. Did you receive funding under Section 330 of Public Health Service Act (funds community health centers, migrant health centers, and health care for the homeless) during this reporting period?

Indicate whether you received funding under Section 330 of the Public Health Service Act (PHSA) during the reporting period. Section 330 is a section of the PHSA that funds community health centers, migrant health centers, and health care for the homeless programs. ***Provide a response to this question only if you have identified the provider type in #7 as "Publicly funded community health center."***

Section 330 of PHSA supports the development and operation of community health centers, migrant health centers, and health care for the homeless that provide preventive and primary health care services, supplemental health and support services, and environmental health services to medically underserved areas/populations.

8. Ownership status

Using the categories defined below, check the box next to the description that best describes the provider's status of incorporation.

Types of ownership status:

Public/local means that the organization is funded by a local government entity and is operated by local government employees. Local health departments are examples of local publicly owned organizations.

Public/state means that the organization is funded by a State government entity and is operated by State government employees. A State health department is an example of a State publicly owned organization.

Public/Federal means that the organization is funded by the Federal government and is operated by Federal government employees. A Federal agency is an example of a Federal publicly owned organization.

Private, nonprofit (not faith-based) means that the organization is owned and operated by a private, not-

for-profit, non-religious-based entity, such as a nonprofit health clinic.

Private, for-profit means that the organization is owned and operated by a private entity, even though the organization may receive government funding. A privately owned hospital is an example of a private, for-profit organization.

Unincorporated means that an agency is not incorporated.

Faith-based organization means that the organization is owned and operated by a religiously affiliated entity, such as a Catholic hospital.

Other means an agency is owned by someone other than those listed above.

9. Did your organization receive Minority AIDS Initiative (MAI) funding during this reporting period? [Yes, No, Unsure]

10. Source of Ryan White CARE Act funding

Check the provider agency's source(s) of funding under Ryan White CARE Act Titles I, II, III, or IV. ***Check all that apply***.

This item includes funding that is received directly from the Federal government (grantee), through a subcontract with a CARE Act grantee (service provider), or through Title II funding to a Consortium.

Title I is the part of the Ryan White CARE Act that provides direct financial assistance to designated EMAs that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals with HIV disease and families; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, when medically appropriate, from inpatient facilities.

Title II is the part of the Ryan White CARE Act that authorizes the distribution of Federal funds to States and Territories to improve the quality, availability, and organization of health care and support services for individuals with HIV disease and their families. The CARE Act emphasizes that such care and support be part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated. The funds are distributed among States and Territories based, in part, on the number of AIDS cases in each State (or Territory) as a proportion of the number of AIDS cases reported in the entire United States.

Title III is the part of the Ryan White CARE Act that provides support for early intervention services, including preventive, diagnostic, and therapeutic services for HIV/AIDS clients. This specifically includes a continuum of comprehensive primary health care, referrals for specialty care, counseling and testing, outreach, and case management and eligibility assistance.

Title IV is the part of the Ryan White CARE Act that supports coordinated services and access to research for children, youth, and women with HIV disease and their affected family members.

Title IV Adolescent Initiative is part of the Title IV program aimed at identifying adolescents who are HIV positive and enrolling them in care.

11. Indicate the amount of funding received during this reporting period for ALL the following categories:

Indicate the total dollar amount received by the provider agency during the reporting period. ***If no funds were received, report "zero" in the space provided.***

a. Title I

Indicate the total dollar amount of Title I (EMA) funds received by the provider agency during the reporting period. This amount does not necessarily reflect how much of the Title I funds were expended by your organization.

b. Amount of 11a from MAI?

12. a) Title II

Indicate the total dollar amount of Title II (State/Consortium) funds received during the reporting period. This amount does not necessarily reflect how much of the Title II funds were expended by your organization.

b. Amount of 12a from MAI?

13. a) Title III

Indicate the total dollar amount of Title III funds received during the reporting period. This amount does not necessarily reflect how much of the Title III funds were expended by your organization.

b. Amount of 13a from MAI?

14. a) Title IV

Indicate the total dollar amount of Title IV funds received during the reporting period. This amount does not necessarily reflect how much of the Title IV funds were expended by your organization.

b. Amount of 14a from MAI?

15. Indicate the amount of Title I, II, III, or IV Ryan White CARE Act funds EXPENDED on oral health care:

Indicate the total dollar amount expended on oral health care by the provider agency during the reporting period. Unlike the previous question, only the funds actually spent on oral health care should be recorded here. ***If no funds were expended, report "zero" in the space.***

16. During this reporting period, did you provide the grantee with support in any of the following areas?

For each of the six services listed, indicate whether the service was provided to the grantee of record by the provider agency by checking "Yes" or "No."

Planning or evaluation is the systematic (orderly) collection of information about the characteristics, activities, and outcomes of services or programs to assess the extent to which objectives have been achieved, identify needed improvements, and/or make decisions about future programming.

Administrative or technical support is the provision of qualitative and responsive "support services" to an organization. Services may include human resources, financial management and administrative services (e.g., property management, warehousing, printing/ publications, libraries, claims, medical supplies, and conference/training facilities).

Fiscal intermediary services include reimbursements received or collected on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts.

Technical assistance or TA is the identification of need for and delivery of practical program and technical support to the CARE Act community. TA should assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating CARE Act-supported planning and primary care service delivery systems.

Capacity development is a set of core competencies that contribute to an organization's ability to develop effective HIV health care services, including the quality, quantity, and cost effectiveness of such services. These competencies also sustain the infrastructure and resource base necessary to develop and support these services. Core competencies include: management of program finances; conducting effective HIV service delivery, including quality assurance; personnel management and board development; resource development, including preparation of grant applications to obtain resources and purchase of supplies/equipment; conducting service evaluation; and cultural competency development.

Quality management is a continuous process to improve the degree to which a health or social service meets or exceeds established professional standards and user expectations. The purpose of a quality management program is to ensure that (a) services adhere to PHS guidelines and established clinical practice; (b) program improvements include supportive services; (c) supportive services are linked to access and adherence to medical care; and (d) demographic, clinical and utilization data are used to evaluate and address characteristics of the local epidemic. It is a systematic process with identified leadership, accountability, and dedicated resources, and uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. It also focuses on linkages, efficiencies, and provider and client expectations in addressing outcome improvement. This is a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement (QI) activities (e.g., JCAHO, Medicaid, and other HRSA programs). Data collected are used to feed back into the process to assure that goals are accomplished and are concurrent with improved outcomes.

17. a.Did you administer an AIDS Drug Assistance Program (ADAP) or local pharmaceutical assistance program that provides HIV/AIDS medication to clients during this reporting period?

Indicate whether the provider agency administered an ADAP or APA program during the reporting period. ***If your response is "No" skip to Question #13.***

ADAP is typically a centrally administered program operated at the State level that receives both Ryan White CARE Act Title II ADAP-earmarked and Title II base funds. Other AIDS pharmaceutical assistance programs typically operate at the local EMA or consortia level. Funds for these programs may come from a variety of sources that are not federally earmarked for AIDS medications. These may include Title I and private sources.

ADAP, AIDS Drug Assistance Program, is a State-administered program authorized under Title II of the CARE Act that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

APA, AIDS pharmaceutical assistance program is a local pharmacy assistance program implemented by a Title I EMA or Title II State. The Title II grantee consortium or Title I planning council contracts with one or more organizations to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., primary care, case management) to the patients or clients that they serve through a Ryan White (or other funding sources) contract with their grantee.

Programs are considered a local APA if they provide HIV/AIDS medications to clients and meet ***all*** of the criteria listed below:

- Have a client enrollment process;
- Have uniform benefits for all enrolled clients;
- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are ***not*** local APAs if they dispense medications in one of the following situations:

- Medications are dispensed to a client as a result or as a component of a primary medical visit;
- Medications are dispensed to a client on an emergency basis (an emergency basis is defined as a single occurrence of short duration); or
- Money or cash vouchers are given to a client to procure medications.

a. Type of program administered

If your agency administers an ADAP or other APA program, specify the program type:

- State ADAP or
- Local pharmaceutical assistance program.

18. Did you provide a Health Insurance Program (HIP) during this reporting period?

Indicate whether your agency provided health insurance through HIP (with Ryan White CARE Act funds) during the reporting period.

HIP is a program that makes premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to keep his or her private health insurance active.

19. Indicate which of the following populations were especially targeted for outreach or services during this reporting period.

Check the box next to each population group that the program specially targeted (set as a goal to achieve and directly allocated funds to support) for outreach efforts or service delivery in the reporting period. The program caseload of clients who are HIV positive may not be entirely representative of the target populations indicated. ***Check all boxes that apply to your agency. If other populations that are not listed here were targeted, check "Other."***

Target population is a population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

If other specify

Report other type of population group, if "Other" was selected as a response in the preceding question.

20. Which of the following categories describes your agency? An agency in which …

Check ***ALL*** categories that describe your agency.

"Other" may be chosen only if none of the other categories describe your agency.

21. Total paid staff, in FTEs, funded by any Title of the CARE Act:

Report the number of paid staff, in full-time equivalencies (FTEs), that were funded by the CARE Act during this reporting period. ***Enter a "zero" if there are no paid staff to report.***

How to calculate FTEs:

Step One: Count each staff member who works full-time (at least 35–40 hours per week) on HIV/AIDS care as one FTE. Full-time employees who regularly work overtime should not be counted as more than one FTE.

If a percentage of each staff member's time is being funded by Titles I, II, III, and/or IV, you can simply add the percentages to calculate the total. For example: Physician .50 FTE, Nurse Practitioner 1.0 FTE, Dentist .20 FTE, Case Manager .75 FTE, C&T 1.0 FTE = 3.45 FTEs.

Step Two: Identify the staff members who do not work full-time on HIV/AIDS care (e.g., part-time employees or full-time employees who spend only a portion of their time in HIV/AIDS care), and sum the weekly hours they spend in HIV/AIDS care. Divide this number by your agency's definition of full-time (e.g., 40 hours per week).

Step Three: Add the FTEs calculated in steps one and two. This sum is the number of FTEs you should report.

22. Total volunteer staff, in FTEs, dedicated to HIV care:

Report the total number of volunteer staff (at all sites within your overall program) in full-time equivalent positions dedicated to HIV care during the reporting period. To calculate FTEs, follow the method of calculation indicated in Question #16. ***Enter a "zero" if there are no volunteer staff to report.***

23. Was HIV counseling and testing provided as part of your program during this reporting period?

Indicate whether HIV counseling and testing were provided as part of your outpatient system of care during the reporting period, either in your facility or by procuring or subsidizing the services provided by other

programs. ***If your response is "No" skip to Question #30***

24. Did your agency provide HIV testing to infants (24 months or younger) during this reporting period?

Indicate whether you provide HIV testing to infants during this reporting period. ***If your response is "No" skip to Question #22.***

Infants are 24 months of age or younger.

a. Indicate the total number of infants tested during this reporting period.

a. Indicate the total number of infants tested during this reporting period who were HIV positive.

25. Were Ryan White CARE Act funds used to support HIV counseling and testing services?

Indicate whether CARE Act funds were used to support HIV counseling and testing services during the reporting period, regardless of where these services were provided (that is, at your outpatient facility or at another site within your program). ***Skip to question 30, if you selected reporting scope 2 for question 6 and do not wish to continue with this section.***

26. How many individuals received HIV pretest counseling during this reporting period?

Indicate the number of individuals who received either confidential or anonymous HIV pretest counseling (counseling before testing for HIV antibodies) by a person qualified to provide such counseling, during the reporting period.

Confidential means information such as name, sex, age, etc., is collected on the client, and the client is reassured that no identifying information will be shared or passed on to anyone.

Anonymous means no identifying information is collected from the client.

27. Of the individuals who received HIV pretest counseling (See #22), how many were tested for HIV antibodies during this reporting period?

Indicate the number of individuals who were tested for HIV antibodies. This item may be a subset of Question #22.

28. Of the individuals who received HIV pretest counseling and were tested for HIV antibodies during this reporting period (See #23), how many had a positive test result during this reporting period?

Indicate the number of individuals who tested positive for HIV antibodies during the reporting period. This item is a subset of Question #23 above.

29. Of the individuals who received HIV pretest counseling and were tested for HIV antibodies during this reporting period (See #24), how many received HIV post-test counseling during this reporting period, regardless of test results?

Indicate the number of individuals who, after being tested for HIV antibodies, returned for HIV posttest counseling from a person qualified to provide such counseling, during the reporting period, regardless of their test results. This includes every person tested for HIV, whether the test result was positive, negative, or indeterminate. This item may be a subset of all clients tested for HIV in Question #23 above.

30. Of the individuals who tested positive (See #25), how many did NOT return for HIV post-test counseling, during this reporting period?

Indicate the number of individuals who had a positive HIV-antibody test result and did not return for HIV posttest counseling, during the reporting period. This may be a subset of the number of individuals who tested positive for HIV antibodies given in Question #24 above.

31. Of the individuals who tested for HIV antibodies and had a positive test result (See #25), how many became new patients at your clinic during this reporting period?

Indicate the number of individuals who tested for HIV antibodies and had a positive test result, and became new patients during this reporting period. The number here should be equal to or less than the number in Question #25 above.

32. Did your program offer partner notification services during this reporting period?

Indicate if you offered partner notification services during the reporting period. If partner notification was offered through referral to another organization, or it is not offered, indicate by "No." This includes notification of both sex partners and injection drug use partners. ***If your response is "No" skip to Question #30.***

Partner notification is when a physician in your program notifies the partner of a client of possible exposure to HIV. It is not the number of individuals who tested positive for HIV antibodies and offered partners' names for notification, nor is it the number of individuals who came to your program because of a referral by a partner notification service.

a. Indicate the number of at-risk partners notified during this reporting period:

Indicate the number of at-risk partners who were directly contacted by a provider to discuss their possible exposure to HIV. Do not count the number of clients counseled on disclosure issues. Do not count number

of clients who were referred to an agency that provided partner notification services.

33. Cost and revenue of primary care and other program during this reporting period:

Your response to each of the following items will indicate the cost of or revenue for providing "Primary care" and "Other program services" as defined below. ***If Title III money was not used to support a particular service, the response for that service should be a " zero." Do not leave any line blank.***

Primary health care is any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a patient who is HIV positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, and pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; HIV counseling and testing; and the cost of making and tracking referrals for medical care.

Other program services, for Title III reporting purposes, refers to optional services that are eligible for Title III funds. Examples include case management, eligibility assistance, social work, outreach, CME, etc. Check the line-item budget on your last approved application for clarity. Do NOT include any administrative costs, expenditures or revenues. If you are providing a Title III eligible service that is *fundable*, include it, even if it is not being *funded* under your grant.

a. Total cost of providing service

Indicate the total cost (personnel, supplies, rent, etc.) to the EIS Program of providing each category of early intervention service, during the reporting period. Each dollar figure should be representative of the amount of money it takes to provide the service as part of the EIS Program.

These amounts are independent of funding sources and will give some indication of the cost for providing HIV-related care.

b. Title III grant funds expended

Indicate the amount of the Title III funds expended to support each category of service during the reporting period. This is the amount of Title III monies used to cover part of the total cost of providing each service.

c. Direct collections from patients

Indicate the amount of money collected directly from clients as payment for services provided during the reporting period. This would include any out-of -pocket payment from clients such as co-payments, deductibles, nominal per-visit fees, etc. This is the amount of money received from patients that is used to cover part of the total cost of providing each service.

d. Reimbursements received from third party payer(s)

Indicate the amount of reimbursements received from third-party payers (public and private) as payment for services provided during the reporting period. This includes reimbursements from Medicaid, private insurance, VA benefits, etc. This is the amount of money that is used from third-party payers to cover part of the cost of providing each service.

e. All other sources of income

Indicate the amount of other sources of income or revenue (other than Ryan White CARE Act Title III), direct collections from patients, and reimbursements received from third-party payers that were used during the reporting period to support services in your EIS program. This is the amount of money that was used from other sources of income to cover part of the cost of providing each service. Other sources may be from city, county, or State agencies; academic institutions, foundations, and corporations; and fundraising activities, bequests, and donations. Any other Ryan White CARE Act funding, such as Title I, Title II, or Title IV, and any other Federal agency funding (CDC, SAMHSA, BPHC, etc.) used to support any category of service should also be included here.

34. Were services available through your Early Intervention Services (EIS) program provided at more than one site during this reporting period?

Record whether the grantee organization provided Early Intervention Services, that is, Title III-eligible services, at more than one site during the reporting period. ***If your response is "No" skip to Question #32.***

f. If yes, how many sites provided EIS services during this reporting period?

Indicate the number of sites at which EIS were provided during the reporting period.

35. Please indicate which of the following primary care services were made available to your clients who were HIV positive during this reporting period.

Check whether each health service was available to patients who are HIV positive, within the EIS program or through referral to providers outside of the EIS program, during the reporting period.

Yes, within the EIS program is a program that encompasses the care supported by the Title III legislation and is made available by the grantee

organization and its subcontractors. Subcontractors render care to clients referred to them by the grantee organization and are reimbursed for their services or otherwise have a remunerative relationship with the grantee for the referred service.

Yes, through referral (Outside the EIS Program) is a referral made to a provider that (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Title III grantee or its parent organization.

It is not necessary to indicate how many patients received each service or how many patient visits were made to obtain each service. All the services you have indicated may not have been utilized during the reporting period. However, the services you have indicated should have been available if a patient had required them within the EIS program or through referral. If services other than those listed below were available, check "other." See list below for a description of services.

Description of services:

Ambulatory/outpatient medical care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to, and provision of, specialty care (includes all medical subspecialties). Primary Medical Care for the Treatment of HIV Infection includes the provision of care that is consistent with the Public Health Service's Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Dermatology refers to care related to the skin.

Dispensing of pharmaceuticals is the provision of prescription drugs to prolong life or prevent the deterioration of health.

Gastroenterology refers to care related to the stomach and intestines.

Mental health services are psychological and psychiatric treatment and counseling services, to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Neurology refers to care related to the nervous system.

Nutritional counseling is services provided by a licensed/registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

Obstetrics/gynecology services refer to care related to the female reproductive organs, including pregnancy.

Optometry/ophthalmology refers to care related to the eye.

Oral health care refers to care related to teeth and gums including diagnostic, preventive, and therapeutic services that are provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries as well as other trained primary care providers.

Rehabilitation services include services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Substance abuse services include the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) provided in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Other services are other Title III-eligible, primary care services not listed above.

36. How many unduplicated patients who are HIV positive were referred outside the EIS program for any health service that was not available within the EIS program during the reporting period?

Indicate the total number of individuals who were referred outside the EIS program for any health service that was not available within the EIS program during the reporting period.

37. For Grantees Only:

What type of quality management program does your agency use to assess services by medical providers during this reporting period? *(Check only one.)*

- ☐ None
- ☐ Quality management program introduced this reporting period
- ☐ Established quality management program
- ☐ Established program with additional quality standards added this reporting period

End of Provider - level form

CLIENT DATA FORM

1. **Client ID or URN**

Report the client's unique ID or Unique Record Number (URN) . The URN is composed of the first and third letters of the client's last name, date of birth, and a code for gender. Grantees may use any unique ID, as long as it is reported consistently over time for the same client.

2. **Client's ZIP code**

Report the client's 5-digit zipcode. If the zipcode is unknown then leave this field blank. If the client is homeless, report the zipcode where the client usually spends the night or the zipcode of the agency.

3. Provider ID number

Report the unique 4-digit provider ID number. This should be the same number that is provided for question 2e on the provider-level form so that the client record can be linked to the provider data file.

4. Enrollment Date

Enter the month, day, and year of enrollment at your agency.

A New client is a person who received services from a provider for the first time ever during the reporting period. Individuals who return for care after an extended absence are not considered to be new unless past records of their care are not available.

5. Gender

Transgender means exhibiting the appearance and behavioral characteristics of the opposite sex, and is based on self-report by the client.

6 Client's year of birth

Report the 4-digit code for client's year of birth. Leave blank if unknown.

7. If year of birth is unknown, what is the client's estimated age?

Report the client's estimated age, if year of birth is not known. ***Client's estimated age must be reported if year of birth is unknown.***

8. Enter client's race/ethnicity

Hispanic or Latino/a is a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

9. What is the client's race?

Report the client's racial group, based on the self-report of the client. All individuals who identify themselves with more than one race should be reported as such. ***Check all that apply***.

White is a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American is a person having origins in any of the black racial groups of Africa.

Asian is a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Native Hawaiian/Pacific Islander is a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

American Indian or Alaskan Native is a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

10. **If the client is new to your service this year, did they enter HIV primary medical care as a result of a routine HIV counseling and testing program?**

0=No; 1=Yes, at this agency; 2=Yes, at another C&T site; 7=Not applicable; 9=Unknown

A routine HIV counseling and testing program is one that is dedicated to providing HIV testing and does not refer to testing that occurs as a result of other care.

11. What is the client's income relative to the Federal Poverty level?

1=Equal or below Federal poverty level
2=101-200%
3=201-300%
4=>300%
9=Unknown/unreported

Report the client's income category, based on the Federal poverty level, at the end of the reporting period, or the most recent data available within the reporting period. Income is defined in ranges relative to the Federal poverty guidelines. Poverty guidelines are posted at: http://aspe.hhs.gov/poverty/

12. What is the client's current housing/living arrangement?

0=Permanently housed includes apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited.

1=Non-permanently housed includes homeless, as well as transient or transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for living. Transitional housing includes any stable but temporary

living arrangement, regardless of whether or not it is part of a formal program.

2=Institution includes residential, health care, and correctional facilities. Residential facility includes supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses.

8=Other means other housing/living arrangements not listed above.

9=Unknown/unreported means housing/living arrangements were not reported.

13. What is the client's current HIV/AIDS status?

1= HIV positive, not AIDS

2= HIV positive, AIDS status unknown

3= CDC-defined AIDS

4= HIV Indeterminate. This applies to infants less than 2 years of age who were born to an HIV-positive mother but whose HIV status is not definite.

5= HIV-negative (This applies to HIV-negative individuals who are affected friends or family due to their relationship to an HIV-positive client. Affected clients must receive at least one CARE Act supportive service to be counted during the reporting period.

6= Unknown/unreported (affected). The HIV status of the individual is unknown.

NOTE: *Once a client has been diagnosed with AIDS, they are always counted in the CDC-defined AIDS category regardless of changes in CD4 counts, etc*.

14. What is the client's current vital/enrollment status?

1=Active is a client whose status is active during any part of this reporting period.

2=Deceased means that the client died sometime during this reporting period.

3=Inactive means that the status of the client is inactive (as defined by your agency), which includes many possible reasons (e.g., client moved or is lost to follow-up). (See question 4 on distinguishing a new from continuing client.)

15. What is the client's current source of medical insurance for HIV-related care.

1=Private means health insurance plans such as BlueCross/BlueShield, Kaiser Permanente, Aetna, etc.

2=Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

3=Medicaid is a jointly funded, Federal-State health insurance program for certain low-income and needy people.

4=Other public means other Federal, State, and/or local government programs providing a broad set of benefits for eligible individuals. Examples include State-funded insurance plans, military health care (CHAMPUS), State Children's Insurance Program (SCHIP), Indian Health Services, and Veterans Health Administration.

5=No insurance means either the client has no insurance to cover the cost of services, or self-pay.

8=Other means client has an insurance type other than those listed above.

9=Unknown/unreported means the primary source of medical insurance is unknown and not documented.

g. If "Other", describe

Report other source of medical insurance if "Other" was selected as a response in the preceding question.

16. Primary risk factor for HIV infection

Persons with more than one reported mode of exposure to HIV are counted in the exposure category listed first in the hierarchy, except for persons with a history of both homosexual/ bisexual contact and injection drug use. They are counted in a separate category. *Check only one response.*

1=Male who have sex with male(s) (MSM) cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).

2=Injection drug user (IDU) cases include persons who report use of drugs intravenously or through skin-popping.

3=Male who has sex with male(s) and injection drug users (MSM and IDU) cases include men who report sexual contact with men and use of drugs intravenously or through skin-popping.

4=Hemophilia/coagulation disorder includes individuals who acquired HIV through receipt of infected clotting factors.

5=*Heterosexual contact* cases are persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., an injection drug user).

6=Receipt of transfusion of blood, blood components, or tissue are cases which transmission by blood , blood components, or tissue transfusion.

7=Mother with/at risk for HIV infection (perinatal transmission) cases include transmission of disease from mother to child during pregnancy. This category is exclusively for infants and children infected by mothers who are HIV positive or at risk.

8=Other means the individual's exposure is known, but not listed above.

9=Undetermined/unknown, risk not reported means the individual's exposure is unknown or not reported for data collection.

17. Does the client have a documented diagnosis of, or were they treated or referred for, substance abuse at at any time this year?

0=No ; 1=Yes

This data element should be obtained through review of medical records or case notes. Substances include injection drugs, marijuana, alcohol, and any other illicit drugs.

18. Does the client have a documented diagnosis of, or were they treated or referred for, a mental health condition at any time this year?

0=No; 1=Yes

This data element should be obtained through review of medical records or case notes. Mental health conditions include depression, psychosomatic disorders, psychosocial disorders, and all other listed conditions in the DSM-IV.

19. **Total number of visits received for each service:**

Enter the total number of visits made for each service category during the reporting period. *Only record service visits that were provided within your organization; do not record outside referrals here.*

NOTE: A client may only have one visit for each service category per day. For a residential substance abuse treatment center, each day in a residential facility equals one visit. For example, if a client spends 20 days in a residential facility, this counts as 20 visits.

Service categories:

a. *Ambulatory/outpatient medical care* is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).

b. *Mental health services* are psychological and psychiatric treatment and counseling services to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

c. *Oral health care* includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

d. *Substance abuse services-Outpatient* are the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) provided in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

e. *Substance abuse services-Residential* are the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) provided in an inpatient health service setting (short-term).

f. *Rehabilitation services* include services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

g. *Home health: para-professional care* is the provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help clients with disabilities remain in their homes.

h. Home health: professional care is the provision of services in the home by licensed health care workers such as nurses.

i. *Home health: specialized care* is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.

j. *Case management services* are a range of client-centered services that link clients with health care, psychosocial, and other services. Ensures timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include: (1) initial assessment of service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of services required to implement the plan, (4) client monitoring to assess the efficacy of the plan, and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services. This includes any type of case management (e.g., face-to-face or via telephone).

k. *Buddy/companion service* is an activity provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

l. *Child care services* are the provision of care for the children of clients who are HIV positive while the clients are attending medical or other appointments or attending Title-related meetings, groups, or training. **NOTE**: This does not include child care while client is at work.

m. *Child welfare services* are the provision of family preservation/unification, foster care, parenting education, and other child welfare services. Services designed to prevent the break-up of a family and to reunite family members. Foster care assistance to place children under the age of 21 years, whose parents are unable to care for them, in temporary or permanent homes and to sponsor programs for foster families. Other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of children who are HIV positive about risks and complications, caregiving needs, and developmental and emotional needs of children.

n. Client advocacy is the provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.

o. Day or respite care for adults is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client.

p. *Developmental assessment/early intervention services* are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. Involves assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. Includes comprehensive assessment of infants and children taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools.

q. *Early intervention services for Titles I and II* are counseling, testing, and referral services to PLWHA who know their status but are not in primary medical care, or who are recently diagnosed and are not in primary medical care for the purpose of facilitating access to HIV-related health services.

r. *Emergency financial assistance* is the provision of short-term payments to agencies, or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

s. *Food bank/home-delivered meals* is the provision of actual food, meals, or nutritional supplements. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

t. *Health education/risk reduction* is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information, including information dissemination about medical and psychosocial support services

and counseling, to help clients with HIV improve their health status.

u. *Housing and housing-related services* are the provision of short-term assistance to support temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related services may be housing in medical treatment programs for chronically ill clients (e.g., assisted living facilities), specialized short-term housing, transitional housing, and non-specialized housing for clients who are HIV affected. Category includes access to short-term emergency housing for homeless people. This also includes assessment, search, placement, and the fees associated with them. **NOTE**: If housing services include other service categories (e.g., meals, case management, etc.) these services should also be reported in the appropriate service categories.

v. *Legal services* are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

w. *Nutritional counseling* is provided by a licensed registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

x. *Outreach services* include programs that have as their principal purpose identification of people with HIV disease so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

y. *Permanency planning* is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

z. *Psychosocial support services* are the provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, and play), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse, or nutritional counseling that are provided to clients, family and household members, and/or other caregivers and focused on HIV-related problems.

aa. *Referral for health care/supportive services* is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.

ab. *Referral to clinical research* is the provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research are studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an institutional review board (IRB) that initially approves and periodically reviews the research.

ac. *Residential or in-home hospice care* means room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

ad. *Transportation services* include conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services.

ae. *Treatment adherence services* are the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

af. *Other services* are other services not listed above.

CLINICAL INFORMATION

20a. **Was client counseled about HIV transmission risk behaviors as part of their primary medical care?**

0=No; 1=Yes; 7=Not applicable; 8=Not medically indicated; 9=Unknown/unreported

(A response of not applicable might be appropriate for infants and toddlers.)

b. If 20a is yes, indicate who performed the counseling.

1=Primary care clinician
2=Case manager/social worker;
3=Other trained counselor.

Clinical Follow-up: Prevention and Treatment

21. TB screening and treatment

Please see the US DHHS Guidelines regarding TB treatment. Go to section "Management of HIV Complications":

http://www.aidsinfo.nih.gov/guidelines/

a. Date of most recent TB skin test: month/year

May be based on patient self-report, if that information serves as the basis for clinical treatment.

Leave blank if unknown. If exact Month of skin test is not known, enter June (mid-year).

b. Result of the most recent TB skin test.

0=Negative (<5 mm)
1=Positive (>=5 mm)
2=Inconclusive
3=Did not return for reading/lost to follow up

c. Documented history of treatment for TB disease or prophylaxis for latent TB infection.

0=No
1=Prophylaxis for latent TB infection
2=Treatment for active disease
3=Unknown/lost to follow-up

d. If patient received prophylaxis or TB treatment, enter date of treatment was *started*. If exact Month of treatment start date is not known, enter June (mid-year).

e. If patient received prophylaxis or TB treatment, enter date of treatment was *Completed*. If exact Month of treatment stop date is not known, enter June (mid-year).

22. a. Was client screened for syphilis:

0=No
1=Yes
3=Not medically indicated

[Syphilis screening includes either non-trepenomal RPR or VDRL tests or the trepenomal antibody test FTA-ABS.]

22b. If syphilis treatment was indicated, was it prescribed?

0=No
1=Yes
9=Unknown/unreported

23. a.) Was the client screened for any sexually transmitted infection (STI) other than syphilis and HIV?

0=No
1=Yes
9=Unknown

Other STIs may include: gonorrhea; Chlamydia; genital warts (HPV); non-specific urethritis.

23b. If treatment was indicated for any STI other than syphilis or HIV, was it prescribed?
0=No
1=Yes
9=Unknown

For Hepatitis A/B/C treatment/vaccine guidelines, please refer to the US DHHS "Management of HIV Complications: Opportunistic Infections Guidelines":

http://www.aidsinfo.nih.gov/guidelines/

24. a. Is client Hepatitis A antibody positive?

0=No
1=Yes

Client may be Hep. A antibody positive as a result of prior infection or from receipt of vaccine.

24b. If antibody positive, enter date of last positive antibody test: month/year. (mm/yyyy)

24**c. Date of first Hepatitis A vaccine dose: (month/year)**

d.) Date of second Hep A vaccine dose:

(month/year)

If exact month of vaccine dates are not known, enter June (mid-year).

25. a. Is client Hepatitis B positive (Antigen or any Hep B Antibody):

0=No
1=Yes

Client may be Hep. B surface antibody positive from prior infection and development of antibodies or from receipt of vaccine.

b. If Hep. B positive, enter data of last positive test: Enter month and year.

Enter Vaccination Dates if Applicable

c. Date of first Hep. B vaccine dose: mm/yyyy

25d. Date of second Hep. B vaccine dose: mm/yyyy

25e. Date of third Hep B. vaccine dose: mm/yyyy

Simply update the vaccine dates as they become available. Leave blank if unknown. Again, months may be estimated or set to June (mid-year) if unknown.

26. a. Date of the most recent hepatitis C screening test: mm/yyyy

Screening date could be from any year, not necessarily the current reporting year.

b. Was the client evaluated for hepatitis C treatment?

0=No; 1=Yes

c. Was the client treated for hep. C?

0=No; 1=Yes

d. If treated, enter date therapy begun: mm/yyyy

e. If treated, enter date therapy completed: mm/yyy

27. **Date of last pneumovax:** mm/yyyy

See Opportunistic infection treatment guidelines for frequency of Streptococcal pneumoniae vaccination: http://www.aidsinfo.nih.gov/guidelines/default_db2.asp?id=69

28. Date of last influenza vaccine: mm/yyyy

An updated Influenza vaccine is recommended yearly.

29. Enter $CD4^+$ T-lymphocyte count (cells/µL) and viral load tests.

a.) Enter the LATEST $CD4^+$ lymphocyte count and viral load test results and date in each quarter, if available.

NOTE: **If the viral load is undetectable, enter 0, regardless of the test/assay used.**

Example: If a client had a CD4 count of 477 in January and 456 in March, then enter March as the month and 456 as the result.

b.) If the client's CD4 lymphocyte count fell below 200 cells, indicate if PCP prophylaxis was begun. Note that you would respond YES here if the client had been on PCP prophylaxis in the past, was taken off because of improvement, but then declined again and PCP prophylaxis was re-started.

0=No;1=Yes; 9=Unknown

30. **Indicate if client was newly diagnosed with any major AIDS defining conditions. Check all that apply. This should only include diagnoses that were new during the reporting period**

See treatment guidelines on prevention of OIs for more information.
http://www.aidsinfo.nih.gov/guidelines/default_db2.asp?id=69

31 a. Was the client prescribed antiretrovirals at any time during the reporting year?

0=No; 1=Yes

NOTE: ***If client is antiretroviral naïve, enter 0.***

31b. If applicable, indicate the LATEST antiretroviral drug *regimen* each quarter. DO NOT report ALL ARVs taken during the quarter.

For example, if the client was on drugs 1, 2, and 3 in January, but switched drug 1 for drug 4 in March, the latest regimen to report would be drugs 2, 3, and 4.
[Use the corresponding numeric code for each drug in the regimen.]
As they become approved, new ARVs will be added to the bottom of the list.

Experimental (not yet fully approved) ARVS should be coded 99.

Code	Antiretroviral medication
1	Agenerase (amprenavir)
2	Combivir (lamivudine/zidovudine)
3	Crixivan (indinavir)

4	Emtriva (emtricitabine)
5	Epivir (3TC, lamivudine)
6	Epzicom (lamivudine/abacavir)
7	Fortovase (saquinavir)
8	Fuzeon (enfuvirtide)
9	HIVID (ddC, dideoxycytidine, zalcitabine)
10	Invirase (saquinavir mesylate)
11	Kaletra (ritonavir, lopinavir)
12	Lexiva (fosamprenavir)
13	Norvir (ritonavir)
14	Rescriptor (delavirdine)
15	Retrovir (AZT, ZDV, zidovudine)
16	Reyataz (atazanavir sulfate)
17	Sustiva (efavirenz)
18	Trizivir (Abacavir/3TC/AZT)
19	Truvada (emtricitabine, tenofovir)
20	Videx (ddI, didanosine, dideoxyinosine)
21	Viracept (nelfinavir)
22	Viramune (nevirapine)
23	Viread (Tenofovir)
24	Zerit (d4T, stavudine)
25	Ziagen (abacavir)
99	Other ARV (experimental)

31c. **If the client did not take any ARVS FOR ANY CONTINUOUS 3 MONTH PERIOD OR LONGER WITHIN THE REPORTING YEAR, indicate reason:**

1= Not medically indicated
2= Not ready (as determined by clinician)
3= Client refused therapy
4= Intolerance, side-effects, toxicity
5= Managed treatment interruption
6= Non-adherent
7= Other reason (e.g. comorbidiy including substance use, mental health problems, inability to pay/lack of insurance.)

Questions 32--34 for Females clients only

32. **Date of last pelvic exam: mm/dd/yyyy**

33. **a. Date last vaginal Pap smear:** mm/dd/yyyy

b.) If no Pap smear, indicate reason:
0=Not medically indicated (e.g. infants/pediatrics)
1=Refused

34. a. Was the client pregnant this year?

Indicate whether the patient was pregnant at any time between January and December.

b. If pregnant, during what trimester did the client begin/enter prenatal/perinatal care:

1=First trimester
2=Second Trimester
3=Third trimester
4=At time of delivery
9=Unknown

c. Did the client receive antiretroviral medications to prevent maternal to child transmission of HIV?

0=No; 1=Yes

Antiretrovirals to prevent mother to child transmission can be delivered to the mother during the last trimester or during labor. See Maternal-Child Transmission perinatal treatment Guidelines.

d. **Did the mother deliver any (liveborn)children this year?**
0=No; 1=Yes; 9=Unknown

e.Total number of livebirths:

f. If 34d is yes, did newborns receive recommended HIV preventive therapies?

0=No; 1=Yes; 9=Unknown

g. Of the children reported in 34e, what was their HIV status at the end of the reporting period:

Enter Number confirmed HIV positive, number indeterminiate, and number confirmed negative.

Please see Guidelines on Maternal-Child Transmission Perinatal Guidelines for preventive therapy with zidovudine, PCP, etc. at: http://www.aidsinfo.nih.gov/guidelines/default_db2.asp?id=66

35. Was this client referred outside the Early Intervention Services (EIS) program (Title III) and/or your network (Title IV) for any service that was unavailable within your program or network?

0=No; 1=Yes; 9=Unknown/unreported

36. Indicate the type of outside referral as well as whether the client received the service.

For all services, record that the patient was referred and whether the patient received the service. ***If the response for the Patient Referred field is "No" or "Unknown/unreported," leave the Patient Received Services field blank.***

END OF CLIENT FORM

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